STATE OF CALIFORNIA

RURAL HEALTH CARE EQUITY PROGRAM (RHCEP) CLAIM FORM

DPA 678 (NEW 9-00)

SUBSCRIBER STATUS (Check one)	RURAL SUBSIDY PLAN YEAR (Check one)
☐ Active ☐ Retired	☐ Plan Year 99/00 (1/1/00 - 6/30/00) ☐ Plan Year 00/01 (7/1/00 - 6/30/01) ☐ Plan Year 01/02 (7/1/01 - 6/30/02)

PLEASE READ THE INSTRUCTIONS ON THE BACK OF THIS FORM BEFORE COMPLETING. PLEASE PRINT IN INK OR TYPE. SEPARATE CLAIM FORMS MUST BE USED FOR THE DIFFERENT PLAN YEARS. ALL RHCEP REIMBURSEMENT CLAIMS RECEIVED BY APPLICATION SOFTWARE, INCORPORATED (ASI) PRIOR TO THE 5TH WORKING DAY OF THE MONTH, WILL BE REIMBURSED WITHIN THE SAME MONTH. CALL ASI AT 1-800-659-3035 FOR QUESTIONS REGARDING RHCEP CLAIMS.

SECTION A — EMPLOYEE/ANNUITANT SUBSCRIBER INFORMATION

LAST NAME	FIRST NAME	SOCIAL SECURITY NUMBER
MAILING ADDRESS	**CITY, STATE, ZIP CODE**	**DAYTIME PHONE (Include area code)**
		( )

SECTION B — OUT-OF-POCKET MEDICAL EXPENSES TO BE REIMBURSED

LIST EXPENSES BY DATES SERVICES WERE INCURRED - SEE BACK OF FORM FOR DEFINITIONS

ITEM NO.	NAME OF PATIENT	RELATIONSHIP TO SUBSCRIBER	DATE SERVICES INCURRED	DEDUCTIBLE/CO-INSURANCE AMOUNT
1				$
2				$
3				$
4				$
5				$
TOTAL REIMBURSEMENT AMOUNT REQUESTED				$

Send one (1) copy of Explanation of Benefit Document (EOB) supporting each item listed. Retain original EOB(s) for your records. Please arrange EOB(s) in same order as listed above and send along with this form to the address below.

SECTION C — EMPLOYEE/ANNUITANT STATEMENT — READ CAREFULLY

I certify that all expenses claimed on this form were incurred during the period while I was eligible to participate in the RHCEP. I understand that "Date Services Incurred" is the date when medical services were rendered, not the date of payment. I certify that the amounts claimed have not been submitted for reimbursement under any other health care plan or program, federal, state or governmental program, workers' compensation, or any other policy of health insurance including the State of California FlexElect Medical Reimbursement Account. I acknowledge that I am fully responsible for the accuracy and validity of all information relating to this claim and my signature to this effect is required below.

EMPLOYEE/ANNUITANT SIGNATURE REQUIRED	DATE
✍	

Send completed RHCEP Claim Form with copies of supporting EOB(s) to:

ASI
P.O. Box 657
COLUMBIA, MO 65205-0657

Email: asi@asiflex.com

Customer Service: 1-800-659-3035
Business Hours: 8 a.m. to 5 p.m. Pacific Standard Time (PST)

PLEASE RETAIN YELLOW COPY OF THIS FORM FOR YOUR RECORDS

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PRIVACY STATEMENT

It is mandatory to furnish all information requested on this form. Failure to provide the mandatory information may result in RHCEP reimbursements not being processed or being processed incorrectly.

The RHCEP administrator requires participant's social security number and name for identification purposes. Legal references authorizing maintenance of this information include Government Code Section 22825.01 and Regulation 4, Section 404.1256, Code of Federal Regulations, under Section 218, Title II of the Social Security Act.

Copies of the RHCEP reimbursement claim form are maintained in confidential files of the RHCEP third party administrator for five years. Employees have the right of access to copies of their RHCEP reimbursement claim forms upon request. The official party responsible for access of this form is ASI, P.O. Box 657, Columbia, MO 65205-0657, Telephone Number 1-800- 659-3035.

CLAIM FILING INSTRUCTIONS

SECTION A

Print your name, address, Social Security Number and your daytime phone number (include area code).

SECTION B

List expenses by date services were incurred and arrange the supporting EOB(s) in the same order. Highlight or circle the service dates on your documentation. If you have several statements from the same provider, you may subtotal them and list them as one item with a range of dates.

Name of Patient – Name of person who obtained medical services.

Relationship to Subscriber – If other than self, describe relationship to subscriber if dependent has received services.

Date Services Incurred – Date service(s) was rendered by medical provider (not the date of payment).

Deductible or Co-insurance Amount – Amount of eligible out-of-pocket medical expenses that State employee/annuitant is claiming for reimbursement (see definitions below).

IMPORTANT: An Explanation of Benefit (EOB) is required to process claims. Contact your health plan for a duplicate copy if necessary. Claims submitted without copies of EOB(s) will be returned.

SECTION C

Read the Employee/Annuitant Statement carefully, then sign and date the claim form. Retain the yellow copy for your tax records. Mail to the address shown on the front of this form.

DEFINITIONS

ASI (Application Software Inc.): The Third Party Administrator (TPA) for the RHCEP.

Co-Insurance: The cost sharing by the plan or insurer and State employee/annuitant of hospital or medical expenses at a specified ratio. The co-insurance ratio for PERSCare is generally 90% for the health plan and 10% for the participant. PERS Choice has an 80% plan/20% participant co-insurance ratio. (Example: A participant incurs medical expenses in the amount of $150. The health plan covers 80% of the total cost, which is $120. The employee's out-of-pocket expense [co-insurance] is $30, which is the only amount eligible for reimbursement under RHCEP)

Deductible: The annual amount of out-of-pocket medical expenses that State employees and annuitants must pay before the health plan begins paying for expenses.

Plan Year: The RHCEP Plan Year corresponds to the State's fiscal year. Plan Year 99/00 is January 1, 2000, through June 30, 2000. Plan Year 00/01 is July 1, 2000, through June 30, 2001. Plan Year 01/02 is July 1, 2001, through June 30, 2002.

Subscriber: State employee/annuitant who meets RHCEP criteria.

ELIGIBLE EXPENSES

Active employees may claim reimbursement of qualifying expenses up to $1,500 per year. For the 1999/2000 Plan Year (representing the period of January 1, 2000, through June 30, 2000), the employee allotment is $750.

Annuitants who are not enrolled in Medicare Parts A & B will be entitled to claim reimbursement of their annual deductible only, up to $500 for a two-party or family enrollment, or up to $250 per year for an individual enrollment.